REFERRAL FORM

Return by Fax to: (321) 639-1194 or by e-mail to: referrals@impowerfl.org

Priority Determination: □ Routine (7 days) **Any urgent referral MUST be called into 321-639-1224**

SERVICES REQUESTED: ☐ **Substance Abuse Residential (ages 13 to 17)** ☐**Counseling** ☐**Psychiatric Clinic**

DEMOGRAPHIC INFORMATION:

Name:____SSN #____________________________

Parents/Caregivers Names:_________________________________Relationship to Client:____________________________

☐ Parent/Guardian home ☐ Relative home, placed by DCF ☐ Foster Home

Address:____County:_________________________

City/State:_____________________________________Zip:________________Email:_______________________________

Phone:____________________________Sex:_________Race:________DOB:_____________________Age:____________

Employer/School:____________________________________Grade: ___________

Client's preferred language:______________Caregiver's preferred language:_______________Bilingual required? YES NO

LEGAL GUARDIAN INFORMATION IF DIFFERENT THAN ABOVE:

Name:______________________________Agency:_____________________________Phone:_________________________

EMERGENCY CONTACT

Name:______________________________Phone:_____________________________Relationship: ____________________

REFERRED BY:

Person completing form:____________________________Referring Agency/Person:_________________________________

Phone:______________________Fax:____________________Email:___________________________Date:____________

Client is currently receiving: ☐In-home / ☐In-school / ☐Individual Therapy / ☐Medication / ☐Other:________________

Provider Name:________________________Agency:_____________________________Phone:______________________

FUNDING INFORMATION

Insurance Name: ____Policy #:_________________________________

☐ No Insurance (staff will reach out to determine funding eligibility) ☐ Private Pay Other Funding:_____________

Briefly describe reason for referral:

CERTIFICATION

I hereby certify that all information I provided is true to the best of my knowledge and belief. I understand that in accordance with Florida Statutes Section 817.50 providing false information to defraud a health care provider for the purpose of obtaining goods andservices is a second-degree misdemeanor:

____ __________________________________

Client/Guardian Signature **Date**